Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Health & Medical Practice

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-05-8115-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 10, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medically necessary"

Amount in Dispute: $267.36

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received however no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 16, 2004	95900	$267.36	$267.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 793 – Reduction due to PPO contract
   - 891 – The insurance company is reducing or denying payment after reconsidering bill

Issues

1. Did the requestor support additional payment is due?
2. Did the respondent support negotiated rate reduction?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.202(d) states "in all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or, (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)." In regards to "Reduction due to PPO Contract", the services in dispute were reduced in part with this explanation code. No documentation was provided to support that a reimbursement rate was negotiated between the workers' compensation insurance carrier Texas Mutual and the health care provider prior to the services being rendered; therefore 28 Texas Administrative Code §134.202(d)(3) does not apply. The carrier's reduction in not supported. Therefore; the services in dispute will be reviewed per applicable rules and fee guidelines.
2. Per §134.202(c) states, "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." The calculation for the service in dispute is as follows: Medicare Physician Fee Schedule for Beaumont is $59.24 x 125% = $74.05 x 4 units = $296.20.

3. The total MAR for the disputed service is $296.20. The carrier previously paid $0.00. The requestor is seeking $267.36. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $267.36.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $267.36 plus applicable accrued interest per 28 Texas Administrative Code §134.803 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 21, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.